DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Lodge at Historic Lewes Senior Living **DATE SURVEY COMPLETED:** October 23, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 20, 2025, through October 23, 2025. The deficiencies contained in this report are based on interviews, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty (80). The survey sample totaled ten (10) residents. Abbreviations/definitions used in this State Report are as follows: DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; RN – Registered Nurse; UAI (Uniform Assessment Instrument) – a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status.		
3225.0 **3225.8.0** **3225.8.1** **3225.8.4** **S/S – D**	**Assisted Living Facilities** **Medication Management** **An assisted living facility shall establish and adhere to a written medication policy and procedures which shall address:** **Residents who self-administer medications shall be provided with a lockable container or cabinet. This requirement does not apply to medications that are kept in the immediate control of the individual resident, such as in a pocket or in a purse. Facility**	A. A lockbox was immediately procured for Resident R10's medicines. All medications are now stored in the lockbox in the resident's apartment, under lock and key. B. All residents who administer their own medications have the potential to be affected. C. A comprehensive review will be conducted of all residents who administer their own medications to ensure each has a lockbox for medications in place and that their medications are secured. Root Cause Analysis of the issue revealed	12/05/2025

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Received 12/3/2025

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	policy must require that medication be secured in a locked container or in a locked room. **This requirement was not met as evidenced by:** Based on observation and interview, it was determined that for one (R10) out of one resident reviewed for self-administration of medications, the facility failed to ensure medications were stored in a locked container. Findings include: 6/2/25 - R10's self-administration of medications was assessed. 10/20/25 10:00 AM - An observation of R10's room revealed that her main door to her room was unlocked, and her prescription medications were in a non-locked drawer in her kitchen. 10/20/25 12:10 PM - During an interview, E3 (Nursing Supervisor) revealed that the Director of Nursing (DON) is responsible for assessing residents for self-administration of medication at admission to the facility. E3 confirmed that R10 did not have a lock box for their medications. 10/21/2025 11:00 PM - During an interview, E2 (DON) confirmed that R10's medication was not kept in a locked container, cabinet, or drawer. 10/23/25 2:00 PM - Findings were discussed with E1 (NHA) and E2 during the exit conference.	the resident was non-compliant with facility protocols of keeping medication in a locked container or their apartment. Resident education on the need to secure medications will be provided to all who self-administer medications (Attachment 1). Those who are unable or unwilling to secure their own medications will have their medications administered by the community staff. Additionally, in-services will be provided to all nurses and medication technicians to ensure they are familiar with the requirement that self-medicating residents secure their medications (Attachment 2). D. The DON/designee will conduct random audits of medication lockboxes of 20% of self-medicating residents to ensure they properly secure their medications (Attachments 3 and 4). These audits will be conducted daily until five consecutive days of 100% compliance, then weekly until 100% compliance is achieved over four consecutive evaluations. Audits will continue monthly until 100% compliance for two consecutive evaluations, then quarterly until 100% compliance is achieved for two quarters. If 100% compliance is achieved for two consecutive quarters the community will conclude the deficiency has been corrected. Audit results will be reviewed at the facility Quality Assurance/Performance Improvement Committee.	
3225.11.0	**Resident Assessment**		

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3225.11.2 **S/S – D**	**A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R2) out of ten sampled residents, the facility failed to revise a UAI-based resident assessment. Findings include: 8/12/25 – An initial UAI was completed for R2. The UAI fall risk assessment recorded that R2 had no falls in the last 30 days or in the last 31-180 days. 8/17/25 – R2 was admitted to the facility. 8/20/25 11:33 PM – A progress notes for R2 documented that, "Resident had fall during fire alarm and hit head – sent to [hospital] for evaluation." 9/17/25 – The 30-day UAI fall risk assessment documented that R2 had no falls in the last 30 days or in the last 31-180 days. The facility failed to update R2's UAI assessment to identify.	A. R2's UAI was reviewed and updated. UAI currently reflects R2's fall status. B. All residents have the potential to be affected. All residents with falls were reviewed against the accuracy of their most recent UAI. C. A comprehensive review will be conducted of Uniform Assessment Instruments (UAIs) for all current residents to ensure they accurately reflect the resident's condition and any changes in condition are appropriately reflected in the latest UAI. Root Cause Analysis of the issue revealed: while the resident's fall status was correctly reflected in their current assessment, that status was not transposed to the UAI in a timely fashion. Additionally, in-services will be provided by the Director of Nursing (RN) to nurses to ensure they are aware of the importance of updating UAIs with any changes the resident may experience since the previous UAI was completed (Attachment 2). D. The DON/designee will conduct random audits of resident UAIs and Service Plans 10% of residents to ensure they are consistent and properly reflect the residents' current condition and service requirements (Attachments 5 and 6). These audits will be conducted daily until five consecutive days of 100% compliance, then weekly until 100% compliance is achieved over four consecutive evaluations. Audits will continue monthly until	12/05/2025

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3225.19.6 3225.19.7 3225.19.7.7.2 S/S – D	10/23/25 11:25 AM – During an interview, E2 (DON) confirmed that the 30-day UAI for R2 did not accurately represent the fall that R10 had on 8/20/25. **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation, or which requires periodic reassessment of the resident's clinical status by facility professional staff up to 48 hours.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R8) out of six residents reviewed for falls, the facility failed to report R8's fall that required periodic monitoring to the State agency within the appropriate timeframe. Findings include: 1/10/25 – R8 was admitted to the facility. 1/12/25 9:06 AM – A progress note documented that R8 had a fall at 8:30 AM with an injury noted to the back of the head. R8 was transported to the hospital. 1/17/25 10:18 AM – The facility submitted an incident report that documented that R8 had an unwitnessed fall in her room and was transferred to the hospital.	100% compliance for two consecutive evaluations, then quarterly until 100% compliance is achieved for two quarters. If 100% compliance is achieved for two consecutive quarters the community will conclude the deficiency has been corrected. Audit results will be reviewed at the facility Quality Assurance/Performance Improvement Committee. A. R8 is no longer a resident of the community. Unable to correct the issue. B. All residents have the potential to be affected. C. A comprehensive review will be conducted of all incidents that were self-reported to the Division of Healthcare Quality from 01/17/2025, onward to determine if any other incidents were reported outside the required timelines. Root Cause Analysis of the issue revealed that the staff nurse reporting the incident experienced difficulties with the new Incident Reporting system. She subsequently submitted the report at a later date, once issues were resolved. All individuals responsible for timely reporting of incidents will be in-serviced by the Director of Nursing (RN) on the necessity to report incidents to the Division of Healthcare Quality timely (Attachment 2).	12/05/2025

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	10/22/25 12:00 PM - During an interview, E2 (DON) confirmed that the incident occurred on 1/12/25 and was reported to the State Agency on 1/17/25 10:18 AM. The facility failed to submit the incident report to the State Agency within eight hours. 10/23/25 2:00 PM - Findings were discussed with E1 (NHA) and E2 during the exit conference.	D. The DON/designee will conduct audits (Attachment 7) of all reportable events to ensure they were reported timely and that mandatory follow-up reporting was completed timely as well. These audits will be conducted weekly until 100% compliance is achieved over four consecutive evaluations. Audits will continue monthly until 100% compliance for two consecutive evaluations, then quarterly until 100% compliance is achieved for two quarters. If 100% compliance is achieved for two consecutive quarters the community will conclude the deficiency has been corrected. Audit results will be reviewed at the facility Quality Assurance/Performance Improvement Committee.	

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